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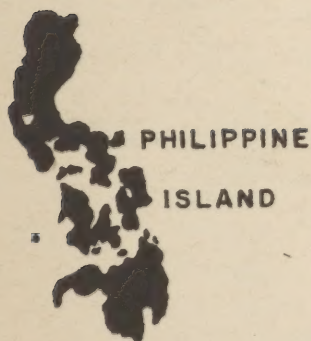
SURGEON'S CIRCULAR LETTER



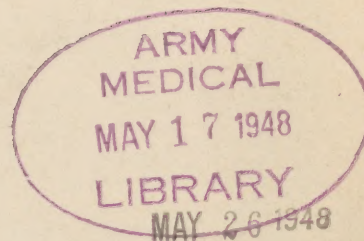
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Organization of the Medical Section

The following is a list of commissioned personnel currently assigned or attached to the Medical Section:

Brig. General James A. Betha
Colonel John C. Fitzpatrick
Lt. Col. Frederick H. Gibbs

Surgeon
Deputy Surgeon
Executive Officer

ADMINISTRATIVE BRANCH

Lt. Col. Frederick H. Gibbs
Lt. Edwin W. Payne
Lt. Elvis E. Bates

Chief
Assistant
Assistant

PLANS AND OPERATIONS BRANCH

Colonel John C. Fitzpatrick
Lt. Col. Frederick H. Gibbs
Major John V. Painter
Major James L. LaCombe
Captain Robert E. Watson
Captain Glenn C. Irving
Captain Felix G. Rajecki
Captain Vincent I. Hack
Captain James D. Grindell
Lt. Maurice F. Watson

Director
Deputy Director
Chief, Supply and Fiscal Branch
Supply and Fiscal Branch
Supply and Fiscal Branch
Supply and Fiscal Branch
Chief, Plans and Operations Branch
Publications, P & O Branch
Medical Records, P & O Branch
Plans and Operations Branch

PERSONNEL DIVISION

Lt. Col. Wilfred A. Emond
Major Sam A. Plemmons

Director
Deputy Director

CONSULTANTS

Colonel Thomas C. Daniels
Colonel George N. Schuhmann
Colonel R. E. Blount
Colonel Irby J. Pollard
Lt. Col. Warner F. Bowers
Lt. Col. R. L. Colhoun
Major Kermit E. Jones

Dental Consultant
Preventive Medicine
Medical Consultant
Veterinary Consultant
Surgical Consultant
Nursing Consultant
Sanitary Engineer

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GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

APO 500

NUMBER. 5

1 May 1948

PART I

ADMINISTRATIVE

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I. Organization of the Medical Section

Arrival in Medical Section. Colonel Irby R. Pollard, VC, formerly of the Quartermaster Depot (Remount), Pomona, California, has been assigned as Veterinary Consultant, Medical Section, General Headquarters, Far East Command.

II. Extracts from the Report of the Last Conference of The Surgeon General
with Army Surgeons and Commanders of Named General Hospitals

a. Address of Welcome by Major General Raymond W. Bliss.

*** We want our doctors to grow professionally. We want them to practice medicine in the Army equal to the best in civilian life. There are only two standards in medicine, good and bad. The Army is interested only in good medicine. To that end we are currently engaged in the elaboration of our postgraduate training program to which so many of you have already contributed so much. I cannot forego telling you that Dr. Thomas of Johns Hopkins University, at the end of his recent tour of duty, reported to General Paul that what he saw of this program at Brooke - and he saw it all - was equal to the best with which he was acquainted in civil life. For a program scarcely more than a year old this was high praise indeed. ***

*** I believe that every doctor in the Army must have a hospital as his base. He must belong. If he is assigned to an outlying dispensary, it does not follow that he must remain there all day. Perhaps two hours in the morning with a nurse on duty all day will be ample. There is no reason why he should not return to his hospital base after his dispensary hours have

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been completed and work in the hospital for the rest of the day. ***

b. Statement of Conference Aims by Brigadier General George E. Armstrong.

*** Gentlemen. Every officer, including those in the Medical Department, must be treated as you and I would like to have been treated twenty years ago. It is a new deal whether we like it or not, and the approach of men like General Willis on my left is the only hope by which I think we may ever expect to attain our goal. Every officer, regardless of the corps, and I dare say almost every enlisted man who reports to Brooke Army Medical Center, is very promptly and personally interviewed by the commanding general of that Center. The man or woman is allowed to discuss freely his or her thoughts regarding the military service. Every opportunity is given to express preference and every opportunity is taken by the commanding general to attempt to solve the medical problem; but that is not all. This same gentleman, and I trust you will pardon this personal reference, does not satisfy himself with the initial personal interview, but from time to time sees these same individuals, especially the younger ones, to discover if they are satisfied with their services and whether or not anything can be done to make their personal or professional life more pleasant and attractive. ***

*** I can remember as a boy that my grandfather told me that in his opinion the art of medicine was ninety-five per cent, the science five. With the increase in technical knowledge I am sure that the latter figure no longer obtains. It is far greater but there still should be a tremendous importance placed on the art. This problem has been discussed with various medical educators, and they agree that the blame should be placed on our medical schools. Be that as it may, we have in the service today several thousand doctors who have not the slightest concept of the proper doctor-patient relationship. ***

*** As mentioned by General Bliss a moment ago, we're trying to build up the concept of a medical center at each post, and, if it is possible, to operate your dispensaries by men assigned to the hospital so that it's a part-time job. That's the idea. If you can't then by all means rotate them. I agree with your thinking that a man learns more medicine in a dispensary than in any other place. It was my experience, and I am sure that it was yours. But that's not the way these lads feel about it today. ***

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III. Army Doctors Go Back to School to Study Relation of Basic Science to Illness

Army doctors are going back to school, but school was never like this! To meet post-war conditions and insure its personnel the best in medical care, the Army has taken a long lead in progressive medical education at the postgraduate level. An important part of the new training program is the Basic Science Course now being given to a group of picked "students" (Army doctors ranging from captains to full colonels) by the Army Medical Department Research and Graduate School at Washington. The course makes use of actual patients as the starting point for discussion of fundamental concepts in the fields of chemistry, physics, anatomy, biology, pharmacology and the other basic sciences as they relate to medical diagnosis and therapy. The 16-week course, now past the halfway mark, represents an entirely new concept in medical education, and has already proved its worth to such an extent that several university medical schools are using it as a model in the reorganization of their advanced courses. Plans are being made to give the course once a year.

As scientific research digs deeper into the nature of things, providing a more accurate picture of matter and energy and their inter-relationship a thorough grounding in basic science becomes more and more important to the practicing physician. Empiricism gives way before specific knowledge. Medical men are constantly whittling away at the percentage of medical failures, and basic science supplies the whittling tools. Doctors are not content with the fact that a given therapy will usually be effective; when the mechanisms of disease and treatment are understood, the physician is able to vary therapy to meet the requirements of each particular patient. As Colonel Walter H. Moursund, Jr., Director of Training at the Army Medical Center, and one of the course's originators, expressed it, "The clinician able to apply the basic sciences at the bedside is a rather rare individual and all too often the press of clinical medicine does not permit adequate coverage of all the phases of the basic disturbances in physiology, biochemistry, pharmacology, etc., which might enter into the consideration of an individual patient."

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The course is divided into three categories: (1) study of how the human body as a whole utilizes and metabolizes essential substances such as water, carbohydrate, protein, etc.; (2) study of how the body handles these substances when affected by modifying agents or situations such as bacterial invasion, heat and cold, heredity, rate of growth, radiation or drugs, and (3) study of the contrast between normal and abnormal functioning of the various systems of the body.

Presentation of separate subjects by the 50 visiting instructors, depends heavily on laboratory demonstrations and actual clinical treatment of selected cases. Each instructor speaks from the wealth of his experience rather than from prepared lecture notes, explaining basic scientific principles as they apply to the case at hand. Note-taking by students is precluded by a complete recording of classroom discussions. Edited and mimeographed copies of the lectures are available to students within a few days of the end of each course. Laboratory and clinic demonstrations are preserved for reference on motion picture film with sound track. Didactic lecture is being held to a minimum and approximately 60% of the allotted time is devoted to laboratory and clinic work. These features in particular of the experimental technique are being watched with great interest by leaders in every educational field.

Crux of the plan's success is the caliber of the instructors. The most distinguished faculty ever assembled for such a course has been recruited from among the outstanding medical and surgical men of the U.S. and Canada. Eminent specialists with varied and heavy responsibilities have agreed to give of their time to the project, persuaded by a firm conviction of the soundness and importance of the experiment.

The first two categories listed have just been completed. Much of the course material is so new that it has not yet been incorporated into standard medical courses, and some of it is being presented for the first time.

Water not only constitutes about 70% of the human body but it provides the solvent or medium in which all the chemical reactions that go to make up life take place. Water metabolism, logically the first subject of the course, was introduced by Professor John K. Peters, Professor of Medicine at Yale University. Tissue electrolytes, the body's extra- and intra-cellular fluids, were described by Dr. A. Baird Hastings of the Harvard Medical School, who explained the gas-liquid-solid relationship of the body under normal and abnormal conditions. Dr. James L. Gamble, well-known pediatrician also of Harvard Medical School, carried the discussion farther into the mechanisms of fluid control in the body and the treatment of pathological states.

The life process is dependent on oxygen to liberate the energy required by every human function and action. Oxygen is particularly interesting from a military standpoint because its scarcity at high altitudes is a limiting factor in aviation. The physical and chemical behavior of oxygen were described by Dr. E. J. Van Liere, Professor of Physiology at the University of West Virginia. Evaluation of external measures to combat the effects of temporary or prolonged anoxia experienced at high altitudes formed an important part of his lecture. Mechanisms by which the body seeks to compensate for a lowered oxygen supply, and the end results of inadequate oxygen intake were covered by Dr. Carl Schmidt of the University of Pennsylvania. Metabolism, the sum of the complicated processes by which a living organism is produced, maintained and supplied with energy, was divided into seven courses. Dr. L. H. Newburgh, Professor of Clinical Investigation at the University of Michigan Medical School, took up energy metabolism especially as it relates to extra-cellular fluid and obesity. The nature and control of enzymes was explained by Dr. V. R. Potter, Professor of Oncology at the University of Wisconsin Medical School. Dr. C. N. H. Long, Dean of Yale University Medical School, covered carbohydrate metabolism; Dr. H. B. Lewis, head of the Biological Chemistry Department at Michigan Medical School, explained protein chemistry, while Dr. L. E. Farr, Director of Research at the Alfred I. duPont Institute of Nemours Foundation, took up the clinical aspects of protein chemistry. The subject of lipids and other fats was introduced by Dr. H. E. Longenecker, Dean of the Graduate School of Pittsburgh University, followed by a course in the physiology and chemistry of lipid metabolism given by Dr. S. J. Thannhauser of Tufts Medical School.

Students learned that vitamin A in excessive amounts is currently suspected of being a poison, causing hemorrhage, bone weakness and liver damage, from Dr. William J. Darby of Vanderbilt University, leading vitamin expert, in the course on accessory factors in metabolism.

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Category 2, the body's behavior under abnormal conditions began with a course on the effects of radiation. Nowhere is the relation of medicine to physics and chemistry more apparent and less understood than in the field of radiation, ranging from application of X-ray and radium techniques to the effect on biological systems of the deadly radiations from atomic fission. From the use of radioactive tracers to determine with precision the course of physiological processes will probably come the greatest medical advances of the future. Instructor in the physical aspects of radiation was one of the country's best known biophysicists, Dr. Robley D. Evans of the Massachusetts Institute of Technology. Biological aspects of radiation, also a pioneer field, was presented by Dr. Shields Warren of Harvard University. Much of his material came from observed effects on human beings of proton, neutron and gamma radiation of the atomic bombs exploded over Japan.

Bacterial invasion of the central nervous system, including the various kinds of meningitis, was taught by Dr. Yale Kneeland, Jr., of Columbia's College of Physicians and Surgeons. Dr. W. B. Wood, Jr., of Washington University, took up the pulmonary infections. Enteric infections are famous for providing some of the most baffling medical mysteries, and this subject was covered by Dr. H. A. Reimann of Jefferson Medical College.

Dr. J. E. Smadel, director of virus research at the Army Medical Department Research and Graduate School, told the class of discovering the new antibiotic, chloromycetin, a drug only now being tested in the field for its ability to stop the spread of dreaded scrub typhus. The course in virus and rickettsial disease also included recent findings concerning the diagnosis and transmission of influenza, Q fever and atypical pneumonia, explained by Dr. A. F. Rasmussen, Jr., Associate Professor of Medical Microbiology at the University of Wisconsin, and Dr. R. L. Gauld of the Army Medical Department Research and Graduate School. Wartime conditions and improved laboratory tests have shown that the latter two, often confused with influenza, are much more prevalent both here and abroad than had ever been suspected.

The tangled threads of heredity are inextricably wound through the practice of medicine, but the subject is primarily one of basic biology, straddling the fields of zoology and botany. Dr. Laurence H. Snyder of the University of Oklahoma, who has spent twenty years in pioneer research on hereditary traits and diseases, described genetic mechanisms as they are now understood. He used as illustration a "map" showing the relative position on the x and y chromosomes of some of the genes carrying sex-linked traits. Dr. Snyder hopes that a complete map of the genes' relative positions may enable doctors to tell which individuals have inherited affected genes from their parents, even before clinical symptoms appear, and to predict the nature and severity of the future course of inherited disease. Such knowledge would make possible the institution of preventive and alleviative measures against the disease early in the life of the affected person.

Few subjects are arousing as much interest in medicine today as that of growth, both normal and abnormal. Upon an understanding of growth mechanics depend rational attacks on the cancer problem. Present status of the field was reviewed by Dr. Stanley P. Reiman, Director of Lankenau Institute of Chemical Research at Philadelphia. Further aspects of cancer research and treatment were covered by Dr. Hugh J. Creech, also of Lankenau Institute, and Dr. Austin Brues of the University of Chicago.

Effect of extreme high and low temperatures on the human body and the control of body temperature were taught by Dr. H. C. Bazett, University of Pennsylvania, Professor of Physiology. The effectiveness of different techniques during convalescence and the mechanism of tissue repair were described by Lieutenant P. H. Henneman, Assistant Instructor at the Army Medical Department Research and Graduate School.

Tropical medicine has always been a subject of particular importance to the Army, and many of the advances in this field were made by Medical Corps officers. Dr. T. T. Mackie, head of the Medical Division of the Bowman Gray School of Medicine, handled this subject.

Prominent in the nightmares of any Army Surgeon is the subject of shock, the strange and still only vaguely understood reaction to severe wounds, surgery, prolonged exposure, etc. Much of the scientific knowledge of shock with its physical and chemical ramifications dates from World War II. Dr. Hans Selye of the University of Montreal, foremost authority and outstanding lecturer, covered this field and pointed the direction future research will probably take.

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With the discovery of the therapeutic value of sulfa drugs and penicillin, the whole subject of chemotherapy took on a vastly increased importance. Dr. A. D. Welch, head of the Pharmacology Department at Western Reserve University gave a general lecture on drugs, while Dr. W. E. Herrell of the Mayo Clinic and University of Minnesota Medical School, described the properties and clinical use of the presently understood antibiotics. Cardiovascular drugs were covered by Dr. Harry Gold, Professor of Clinical Medicine at the College of Physicians and Surgeons.

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IV. Army Doctors Told of New Discoveries Regarding Virus and Rickettsial Diseases

Discoveries regarding virus and rickettsial diseases which are so new they have not yet been included in standard medical school courses have been announced to Army doctors attending a new kind of Basic Science Course currently given at the Army Medical Department Research and Graduate School. New facts, concerning influenza, primary atypical pneumonia, and "Q" fever, were included in a most complete and up-to-date series of lectures and demonstrations just concluded on these diseases, according to Dr. J. E. Smadel, Director of the Virus and Rickettsial Division of the School.

The function of the Army's system of watch posts for influenza was explained by Dr. A. F. Rasmussen, Jr., Associate Professor of Medical Microbiology and Preventive Medicine at the University of Wisconsin. Established over a year ago, watch posts throughout the U.S. and several at key overseas posts keep a sharp lookout for outbreaks of flu. The value of the system in spotting epidemics was illustrated in Los Angeles last December when an epidemic of mysterious diseases labeled "virus X" spread through the city almost over-night. Within six days Captain Henry Kempe, of the Army Medical Department Research & Graduate School had demonstrated that the virus responsible for the respiratory phase of the diseases lumped together as "virus X," was influenza virus A, the same flu strain responsible for the epidemic of January 1947, but quite different from the flu virus of 1943 and 1945. The clinical symptoms of flu can be produced by a number of different disease infections, but serological tests will definitely show the difference. Within seven to ten days after the disease is contracted antibodies are built up in the blood of the patient in sufficient quantity to be identified by laboratory test. It is hoped that findings from research now in progress on the mild flu viruses will supply the information necessary to control another epidemic of the virulent flu virus of 1918, should it reoccur.

A phenomenon now causing speculation is the occurrence of "late flu" two years in a row. The interval between influenza outbreaks is usually several years. A flu epidemic usually begins late in the year, but rarely starts after the middle of January. Last year an epidemic occurred late in January and during late February there were a number of small groups of cases scattered along the east coast.

The unsuspected widespread incidence of Q fever was pointed out by Dr. R. L. Gauld of the Army Medical Department Research and Graduate School. Until 1945, it was thought that Q fever, a virus infection very similar to primary atypical pneumonia, was confined to Queensland, Australia; hence its name. Blood tests made among our troops in Italy in April 1945, however, showed that a severe epidemic of what had been diagnosed as atypical pneumonia was actually Q fever, and further research brought to light its occurrence in Greece, Syria and Palestine, and as far west as Tripoli, Spain and Portugal. There have even been recent outbreaks in the U.S. Last May there was a small outbreak at Munich, Germany. Accurate diagnosis is important in controlling the spread of the disease since flu and atypical pneumonia can be transmitted from person to person, but it is fairly well established that transmission of Q fever is always associated with animals. Inhaled dust containing dried excreta from infected animals is thought to be the source of infection.

The Army Medical Corps' Basic Science Course will run for sixteen weeks altogether, and will cover the relationship of the basic sciences to diagnosis and therapy. It was designed to familiarize Regular Army Medical officers with the newest findings in the basic sciences as related to their special fields.

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V. Excerpts of Letters Recently Received by Office of The Surgeon General
and the Reply to One of Them by R. W. Bliss, Major General,
The Surgeon General

Dear General Bliss:

5 March 1948

On my way back from, I stopped off at the General Hospital to visit my son, who is interning there. I want to tell you how kind and courteous Colonel was to me, and how he spent considerable time in showing me thru that wonderful institution.

It is my confirmed opinion that you have the finest and best training program in existence today; far superior to any civilian hospital, and because of this, have urged my son to apply for a commission in the Regular Army and make it his life's work.

Sincerely,

..... M.D.

Dear General Bliss:

2 March 1948

I was a patient at General Hospital from 2 February to 26 February. I was operated on and after a period of convalescence, was returned to duty. During that time I was under the care of and

Perhaps it is inappropriate for me to write to you commending these officers and personnel of Ward under nurse for the excellent treatment that I received while in their hands. However, I know of no other way in which I could express my appreciation for the service to date, I have never stayed in a ward that has been run half so well as Ward Every member of the ward is solicitous about the comfort of the patients under them and is extremely courteous in the performance of their duties. No matter how minor the ailment, every patient receives sympathetic treatment. Everyone is treated as a friend, and as a result there are no strangers in the ward. Several of the foreign officers commented particularly on this fact.

Let me repeat that I send this letter to you because I felt called upon to give you an outsider's viewpoint of how efficiently your establishment runs.

Respectfully yours,

....., GSC

DEPARTMENT OF THE ARMY
Office of The Surgeon General
Washington 25, D. C.

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9 March 1948

Dear _____:

Thank you for your letter stating your appreciation of the manner of your treatment and care while you were a patient at General Hospital.

It is our constant aim that every patient in every army hospital receive the highest type of professional care. We hope that this care is always given in an atmosphere of kindness, courtesy and good will.

I am taking the liberty of forwarding your letter to the Commanding General of General Hospital for his information and appropriate action.

Sincerely,

R. W. Bliss, Major General
The Surgeon General

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VI. Medical Corps Officer's Letter to Medical Section, Far East Command,
Expressing Appreciation for Army Training

To, Colonel, MC, USA
General Headquarters, Far East Command

7 March 1948

1) Now, on the occasion of my separation from the Army of the United States, I wish to extend to you and to the Medical Corps, my thanks for the opportunities which I have enjoyed while on active duty.

2) I have received medical training which I believe is as varied and good as that which I might have received anywhere.

3) The places I have seen, and the experiences I have had are considerably beyond anything I had expected or imagined before beginning this tour of duty.

4) As I reenter civilian life at this time, it will be with pleasant memories of the time spent in the Medical Corps.

Sincerely,

....., Captain, MC

VII. Preventive Medicine Gets Interim Specialty Board

Consultants and practitioners of preventive medicine, one of the least formalized but most universally important branches of medical science, today learned that a great forward step toward professional recognition of their calling as a distinct medical specialty has been made by the formation of an "Interim Board" of Preventive Medicine. Announcement of the move was made jointly by the Surgeons General of the Army, Navy and U.S. Public Health Service.

War and postwar conditions have emphasized the need for uniformly high standards in the field of public health and preventive medicine, and the Interim Board was formed chiefly for the purpose of setting up certification requirements for medical officers seeking to qualify as specialists. The cooperative effort of these three services will undoubtedly give impetus to a growing demand for creation of an American Board of Preventive Medicine and Public Health to take its place along with the 16 medical specialty boards already in existence and supply the uniform professional standing and protection specialists need in order to function most effectively.

Members of the Interim Board were selected with great care. Several weeks ago the three Surgeons General formed an advisory committee to consider the problem. Through a pooling of recommendations, a panel was formed of men throughout the country who were considered the most distinguished in the field of public health and preventive medicine. From this panel, six civilian authorities on the specialty were chosen and all accepted an invitation to form the Interim Board. They are: Dr. Ernest L. Stebbins, director of Johns Hopkins University School of Hygiene & Public Health; Dr. Wilton L. Halverson, California State Director of Public Health; Dr. Harry S. Mustard, New York City Health Commissioner; Dr. Thomas Francis, Jr., University of Michigan School of Public Health; Dr. Gaylord W. Anderson, director of the University of Minnesota School of Public Health; and Dr. Hugo Muench, assistant dean, Harvard School of Public Health. Chiefs of the preventive medicine divisions of the Army and Navy and an officer selected by the Surgeon General of the Public Health Service, complete the roster. They are: Dr. James Crabtree, Deputy Surgeon General, U.S. Public Health Service; Colonel Tom F. Wayne, Chief, Preventive Medicine Division, Office of The Surgeon General, U.S. Army, and Captain Otto L. Burton, Chief, Preventive Medicine Division, Bureau of Medicine and Surgery, U.S. Navy.

At its first meeting the Interim Board began drafting a preliminary bill of requirements for certification and elected Dr. Stebbins chairman. Confidence was expressed that official standards for qualification as a specialist in preventive medicine will soon be achieved.

Preventive medicine and public health, although practiced long before most of the

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other medical disciplines in the form of primitive tribal taboos has lagged behind other branches of medicine in organization and recognition. Today the work of the various groups interested in research and practice in this field is largely uncorrelated. Investigations into industrial and personal hygiene, nutrition, water supply and sewage disposal, mechanisms of disease transmission, pest control, housing and ventilation, and all the other multifarious aspects of preventive medicine and public health, are for the most part carried on independently by many private concerns and various agencies of State and Federal governments. Practitioners in different lines and different areas have no uniform professional qualifications. With its own specialty board and its own professional organization, this field could maintain its integrity and command uniform national recognition. The joint action of the Army, Navy and Public Health Service announced today is a step in this direction.

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VIII. Philippines-Ryukyus Command Medical Service Corps Association

On 7 January 1948 at the 10th General Hospital, a meeting was held by the Medical Service Corps Officers in the Manila Area. The meeting was called to discuss "Training Classes for Medical Service Corps Officers." Colonel Roy E. Fox, MC, Commanding Officer, Medical Service, Philippines, discussed the possibilities and objectives to be obtained by an organization of the Medical Service Corps officers. An organization was formed and the following officers elected. Major James E. Hardin, MSC, was elected President, Major Otto T. Conner, MSC, was elected Vice-President and Captain Nathan R. Wisser, MSC, was elected Secretary. The first meeting was adjourned after a program and meeting place had been set for the following month.

The second meeting was held on the 4th of March, 1948 at the PHILRYCOM Medical Depot. After discussions on the old and new business of the organization, a talk on Personnel Problems was given by Captain P. R. Young, followed by a discussion of the mission and the history of the PHILRYCOM Medical Depot by Lt. J. Pokras. The meeting was concluded with a tour of the Medical Depot.

If other Medical Service Corps officers are interested in any information regarding the Philippines-Ryukyus Command Medical Service Corps Association, it is requested they write to Captain N. R. Wisser, at the 993rd Medical Depot Co (PS) APO 900, c/o Postmaster, San Francisco, California.

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IX. Future Integration Program for the Army Nurse Corps and Women's Medical Specialist Corps, Regular Army

A recent communication received from The Adjutant General, Department of the Army, indicates that plans are now being formulated for future procurement of officers for the Army Nurse Corps and Women's Medical Specialist Corps sections of the Regular Army.

It is suggested that Nurses, Dietitians and Physical Therapists who did not apply for Regular Army appointment under the recently completed integration program and who are now interested in a Regular Army career be advised of the fact that opportunity to apply will be afforded them upon receipt of Department of the Army directive.

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X. Medical Specialists to Lecture at Far East Command Hospitals

Three medical specialists have arrived from the United States for a lecture tour of the principal hospitals in the Far East Command. They are Dr. Milton C. Cobey, orthopedic surgeon of Washington, D.C., formerly a teacher at Johns Hopkins University and now lecturing at Georgetown University; Dr. Edmund Horgan, former professor of surgery, Georgetown University, and Dr. Samuel A. Overstreet, Assistant Professor of Medicine, University of Louisville.

Their visit to the Far East Command is part of an overall program set up by the

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Consultants Division of The Surgeon General's Office to send expert medical consultants to the various foreign theaters. They will visit as many Far East Command hospitals and lecture to as many Army doctors on the modern advances in medicine as their time in Japan will permit.

This will be a means of establishing better liaison so that Medical officers can obtain additional training and experiences from these clinics.

XI. Delay in Receipt of Medical Professional Journals

Reference is made to Surgeon's Circular Letter, 1 May 1948, Section VIII, Medical Professional Journals, page 4. The Army-Navy Medical Procurement Office is experiencing difficulty in securing bids on subscriptions to medical journals, due to reluctance on the part of publishers to quote firm prices in view of unsettled market conditions. Consequently, there will be some delay in receipt of journals for the first few months of 1948.

XII. Intravenous Solutions

The Surgeon General has determined that stocks of the following items which were manufactured or procured more than two years prior to date of issue are unsafe for medicinal purposes. Destruction of such stocks is authorized under the provisions of Paragraph 111c, TM 14-904. However, if containers can be disposed of economically through salvage, the contents only should be destroyed.

- 1-164-600 Dextrose Injection, 5%, 1000 cc, 6s.
- 1-165-000 Dextrose and Sodium Chloride Injection, 1000 cc, 6s.
- 1-429-500 Sodium Chloride Isotonic Solution, 1000 cc, 6s.
- 1-491-720 Water for Injection, 1000 cc, 6s.

XIII. Recent Department of the Army and FEC Publications

AR 1-10, DA, 1 Jan 48. List of Current and Suspended Pamphlets, Page 11, Medical Department.

AR 40-105, C-1, DA, 23 Jan 48, CORRECTED COPY. Medical Department, Standards of Physical Examination for Commission or Warrant in Regular Army, National Guard of United States, Army of United States, and Organized Reserves.

AR 40-205, C-3, 9 Mar 48. Medical Department - Military Hygiene and Sanitation.

AR 40-210, C-7, DA, 10 Mar 48. Medical Department - Prevention and Control of Communicable Diseases of Man.

CIR 18, DA, 22 Jan 48. Sec II, Films & Film Strips Distributed During December 1947.

CIR 26, DA, 2 Feb 48. Sec VI, Status of Army of the United States Officers.

CIR 27, DA, 3 Feb 48. Extended Active Duty.

CIR 28, DA & AF (AF Ltr 35-103), 4 Feb 48. Appointment of Enlistment of Military Personnel in the Organized Reserves.

CIR 29, DA, 5 Feb 48. Sec I, AR 40-1025 - Records and Reports of Sick and Wounded - Changed.

CIR 34, DA & AF (AF Ltr 25-22), 10 Feb 48. Venereal Disease Control Survey (Reports Control Symbol MED-(OT)-44).

CIR 35, DA & AF (AF Ltr 80-26), 11 Feb 48. Disposition of Exposed X-Ray Films.

CIR 36, DA & AF (AF Ltr 35-21), 11 Feb 48. Military Records, Officers' Separation Certificates.

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CIR 37, DA, 11 Feb 48. Sec III, Circular - Expiration Dates Extended (See pars 1 and 6); Sec VII, Organized Reserve Corps, Except General Officers - Par 6a, b, c, WD Cir 356, 1946 Pertaining to Boards - Amended; Sec VIII, Relief of Officers, Warrant Officer and Flight Officers from Active Duty.

CIR 38, DA & AF (AF Ltr 35-13), 12 Feb 48. Career Guidance - Appointment of Warrant Officers to the Regular Army and United States Air Force - Certain Parts Pertaining to Medical Department.

CIR 40, DA & AF (AF Ltr 25-4A), 16 Feb 48. Subsistence in Hospital Messes - DA Cir 14, Amended.

CIR 43, DA, 18 Feb 48. Sec III, Films - Distributed During Jan 48; Sec VI, Mailing Address, Army Institute of Pathology; Sec VII, Organized Reserve Corps, Except General Officers.

CIR 45, DA & AF (AF Ltr 80-30), 24 Feb 48. Records Administration - Management and Retirement of Files. Sec I, T/O Units.

CIR 49, DA, 25 Feb 48. Sec II, Engineering Development Division, Army-Navy Medical Procurement Office - Change of Address.

CIR 56, DA, 3 Mar 48. Sec IV, Reception Processing of Enlisted Men - Pertaining to X-Ray, etc.

CIR 58, DA & AF (AF Ltr 25-8), 5 Mar 48. AR 40-505, Amended.

CIR 60, DA & AF (AF Ltr 80-30), 8 Mar 48. Records Administration - Management and Retirement of Files; Sec I, T/O Units. CIR 45, DA, listed above, rescinded.

CIR 61, DA, 9 Mar 48. Sec 1, Circular - Expiration Dates Extended (See Par 2.).

CIR 68, DA, 15 Mar 48. Sec IV, Medical Department Officers - Applications for Training at Civilian Institutions.

BUL 3, JAAF, 30 Jan 48. Sec III, Executive Order - Permanent Promotion of Officers in Medical Department of Army, Suspending Professional Examination.

G.O. #11, DA, 2 Feb 48. Recommended Lists for Promotion to Colonel, Par 1b, Medical Corps, RA.

G.O. #14, DA, 11 Feb 48. Sec I, ROTC Units - Medical Corps ROTC Units Established.

MEMO 615-515-1, C-4, DA, 9 Feb 48. Selection of Personnel from Replacement Stream for Army Schooling. Sec IV, Line #37 - Medical Department.

FM 8-50, C-3, 11 Feb 48. Bandaging and Splinting.

TB MED 31, DA, 21 Jan 48. Scrub Typhus Fever (Mite-borne Typhus, Tsutsugamushi Disease).

SB 8-37, DA, 2 Feb 48. Denture Teeth, Facings and Backings.

T/O & E 7-18N, DA, 30 Dec 47. Infantry Heavy Weapons Company, Sec III, Equipment - Med Dept.

T/O & E 5-217N, DA, 15 Jan 48. Armored Engineer Company, Sec III, Equipment - Medical Department.

T/O & E 8-7N, DA, 6 Jan 48. Medical Company, Infantry Regiment.

T/O & E 17-27N, DA, 21 Jan 48. Medium Tank Company - Sec III, Equipment - Medical Department.

T/O & E 17-37N, DA, 26 Jan 48. Heavy Tank Company - Sec III, Equipment - Medical Department.

T/O & E 17-57N, DA, 23 Jan 48. Reconnaissance Company - Sec III, Equipment - Medical Department.

CIR 3, GHQ, SCAP, 25 Feb 48. Private Commercial Entrants (See Sec VII, Par 24 d & g).

CIR 4, GHQ, SCAP, 4 Mar 48. Control of Traffic and Vehicles in Japan - See par 3 b (1) pertaining to Ambulances.

CIR 8, GHQ, SCAP, 18 Mar 48, Procurement Regulations and Procedures Within Japan (See Par 4c).

CIR 6, GHQ, FEC, 17 Feb 48. Employees' Compensation for Disability and Death.

CIR 8, GHQ, FEC, 2 Mar 48. Immunization - Rescinds GHQ FEC Cir 34, 1947.

CIR 9, GHQ, FEC, 10 Mar 48. Construction Policy for Japan and Korea - Certain Parts Pertaining to Hospital Construction, Nurses and W.M.S.C. Quarters.

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CIR 14, GHQ, FEC, 26 Mar 48. Administration of Non-Appropriated Fund Employees. Par 16, Hospitalization.

PART II

TECHNICAL

SUBJECT

SECTION

Cholecystitis, Acute. XIV
Chronic Alcoholism and the Conditioned Reflex Treatment XV

XIV. Cholecystitis, Acute. Case Reports by 1st Lieut. Walter D. Comeaux, Jr., MC, 49th General Hospital, Tokyo, Japan. Discussion by Lt. Col. Warner F. Bowers, MC, Surgical Consultant, Medical Section, General Headquarters, Far East Command.

Case #1. Cholecystitis, Acute, Cause Undetermined. A 44-year old officer was admitted to the 49th General Hospital on 26 February 1948 from his Unit Dispensary. Four days prior to admission patient had intermittent lower abdominal pain, gnawing in character, aggravated by movement and deep breathing and relieved by rest and flexion of thighs on abdomen. Pain became constant in character and of increased severity at noon 25 February 1948. With onset of constant pain, appetite was impaired. He had no nausea or vomiting. For the past four days he had nocturia and a feeling of "fullness" in the lower abdomen after micturation. No dysuria, no hematuria, no abnormal urine color. Urination did not relieve his pain. He gave no selective dyspepsia or ulcer history. He has noticed in the past year much belching and passing of flatus by rectum.

One year ago patient had a similar attack except that it was accompanied by nausea, vomiting, and diarrhea. At that time he received relief with tincture of belladonna.

On admission to hospital patient was in pain, with temperature 100.8, pulse 78, respiration 19, blood pressure 120/80, generalized lower abdominal tenderness, more pronounced over right lower quadrant of abdomen, and right lower quadrant rebound tenderness. A right indirect inguinal hernia was present. Flat plate of abdomen was negative; WBC 23,350 with 74% polymorphonuclears, urine negative.

Patient was operated upon on day of admission through a right lower paramedian incision. An obstructive, non-acute, obliterative, appendix was removed in retrograde fashion--stump tied but not inverted. Lower ileum was explored for a Meckel's diverticulum but none found. The cause of the patient's abdominal pain was found to be an acutely distended, tense gall bladder. Due to the elapse of 4 days between onset of symptoms and operation the gall bladder was not removed.

Postoperatively patient was placed on 100,000 units of penicillin q. 3 hours for five days. He was afebrile on the third postoperative day. Convalescence was then essentially negative. On 15 March 1948 a gall-bladder series was performed which showed several large radio-lucent calculi. Patient was discharged from the hospital on 17 March 1948 with no complaints. It is contemplated that a cholecystectomy will be performed in approximately one month.

Case #2. Cholecystitis, Acute, (Empyema) Secondary to Escherechia Coli. A 45-year old officer was admitted to the 49th General Hospital on 3 March 1948. At 0400, 3 March 1948 patient was awakened by an acute, aching, continuous epigastric pain which did not radiate. Pain was followed in 45 minutes by vomiting of a yellowish fluid. Patient had a similar episode of epigastric pain two days prior to admission which lasted 20 minutes and was relieved by Alka Seltzer. His past history was negative. He has had no selective or quantitative dyspepsia.

On admission to the Medical Service, this hospital, patient was in acute pain; with

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temperature 98, pulse 54, respiration 16, blood pressure 160/90, WBC 12,200 with 71% polymorphonuclear cells, Hb 15.5 Gms. EKG was negative. Flat plate of abdomen in upright position showed no free air under diaphragm.

By 4 March 1948 pain had localized under the right costal margin and was steady in character. No rigidity was present but voluntary muscle spasm was increased. Peristalsis was active and temperature was normal. At 1400, 4 March 1948 patient developed a temperature of 102, a white count of 24,450 with 87% polymorphonuclear cells. Surgical consultation was obtained and a diagnosis of acute cholecystitis entertained. Patient was transferred that evening to the Surgical Service for further observation.

Throughout the day of 5 March 1948 pain increased in severity, was not appreciably relieved by amyl nitrite pearls or nitroglycerine. Temperature increased to 103.2, pulse to 92. By 0500 this date patient developed a severe generalized chill and at this time physical examination revealed a faint outline of mass in the right lower costal margin. Clinical icterus was noted for the first time. WBC was 24,450, with 88% polymorphonuclear cells. By 1800 pain in the right upper quadrant of the abdomen was intense, muscle spasm and rebound tenderness was present. Because of the increasing pain, generalized chill, increased temperature, increased white count, and increased pulse, surgical intervention with drainage of an empyema of the gall bladder was believed indicated.

At operation, through a right subcostal Kocher-type incision, an enlarged, acutely distended, tense, inflamed gall bladder was found to which the omentum had become loosely adherent. A trochar was inserted into the fundus of the gall bladder and 80 c.c. of thick, purulent, chocolate colored material removed. A #12 F catheter was inserted into the upper portion of the gall bladder through the trochar, trochar removed, and previously inserted purse-string suture drawn tight. Catheter was brought out through a separate stab wound in the right flank. A large palpable stone, 1 cm in diameter, was found present in the neck of the gall bladder. Culture of material from gall bladder was taken at operation and later reported as "pure culture of *Escherichia coli*".

Postoperatively patient was placed on sulfadiazine and penicillin for five days. His convalescence was uneventful, icterus disappeared and stools became dark in color. By 16 March 1948 bile drainage from cholecystostomy tube was minimal and it was removed. Immediately following surgery patient volunteered the information that he was "much relieved."

Following laboratory findings were recorded: 4 March 1948--Serum Amylase 79 Somogyi Units; 5 March 1948--Serum Protein 6.1 Gms. percent, albumin 4.15, Globulin 1.95; 6 March 1948--Icterus Index 40, Urea Nitrogen 13, Blood Chlorides 433, Serum Protein 5.9 Gms. percent.

Patient as of 17 March 1948 is still in hospital, up and about, comfortable, with no complaints. A cholecystogram is to be taken. Cholecystectomy will probably be performed.

DISCUSSION:

Any discussion of acute cholecystitis is futile unless basic mechanisms are well understood. First then, what is the pathogenesis of acute cholecystitis? From clinical and experimental evidence, it seems clear that acute cholecystitis is a mechanical phenomenon based on alterations in motor activity of the gall bladder and sphincter of Oddi which, in turn, upset the normal secretory gradient.

Probably the normal mechanism of gall bladder emptying depends on acid gastric content entering the duodenum where cholecystokinin is activated. This hormone then induces relaxation of the sphincter and contraction of the gall bladder. If, for some reason, (muscle dysfunction or obstruction by stone or tumor) the sphincter does not relax, the gall bladder is unable to empty itself, because the motor power of the gall bladder is insufficient to overcome the sphincter. At this point, then, the patient experiences a colicky type of pain due to distension of the hollow viscus. If this were the end of the story, no serious consequences would eventuate. However, depending upon the phase of secretory pressure, bile may enter the pancreatic duct or pancreatic secretion may enter the common duct and gall bladder. This is possible in some 60% of individuals who are anatomically so constituted that the common and pancreatic ducts

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enter the duodenum simultaneously.

If bile enters the pancreas, pancreatic enzymes are activated and acute pancreatitis results. This may progress to hemorrhagic necrosis or may stop at edematous pancreatitis depending upon the degree of chemical inflammatory reaction. If pancreatic juice enters the gall bladder, a severe inflammatory reaction results evidenced first by edema which is harmful not only because it obstructs the cystic duct, but because it inhibits motor activity. Consequently, the gall bladder is unable to empty itself. That this mechanism acts in clinical cases is evidenced by the fact that pancreatic enzymes can be demonstrated with regularity in the gall bladder content in cases of acute cholecystitis.

Experimentally, the goat is the best laboratory animal, because its duct system permits ligation so that pancreatic juices can enter the gall bladder. This regularly produces severe acute cholecystitis which usually regresses if obstruction is relieved. It is possible by this experiment actually to produce gall stones in these animals.

The next question of interest relates to why the acutely inflamed gall bladder perforates. Distension of any hollow viscus constricts the blood supply of the wall and causes acute inflammatory changes even in the absence of bacteria. If distension is to the point of ischemia, gangrene and subsequent perforation will result. The normal function of the gall bladder includes absorption of water from bile and secretion of mucus and calcium carbonate solution. In the presence of obstruction, secretion may continue especially if inflammatory edema is present. If secretion over-balances absorption in the presence of obstruction, obviously increased distension will eventuate.

However, it is my experience that perforation of the gall bladder is uncommon and acute cholecystitis can in no way be compared to acute appendicitis in this respect because the appendix perforates in a high percentage of obstructive cases.

Bacteria play a small role in acute cholecystitis which is primarily an obstructive phenomenon. Some writers state, categorically, that there is no such thing as empyema of the gall bladder and that the purulent material sometimes seen in obstructed gall bladders is sterile and owes its appearance to cholesterol crystals and precipitated calcium carbonate. It is further reported that in over 50% of cases, the fluid from acutely obstructed gall bladders is sterile on culture. In some 25% of cases, *E. coli* can be demonstrated. In the other 25% of cases, a mixed flora is found. It should be remembered in this connection that normal bile often contains a fairly high bacterial count and it has been shown that in acute cholecystitis the bacterial count is often lower than in normal bile. This is thought to mean that the chemical reaction actually kills bacteria in the gall bladder.

From this, it will be seen that the simple presence of bacteria in cases of acute cholecystitis does not establish their causal relationship.

With regard to symptoms, early, the pain is recurrent and colicky in nature due to the fact that the gall bladder is actively attempting to empty itself against resistance either in the cystic duct or at the sphincter of Oddi. Later, if obstruction persists, the pain is constant and is due to an unrelenting distension which causes pain in any hollow viscus.

It is said that vomiting rarely occurs in gall bladder disease unless the common duct is involved. A more accurate statement of this would seem to be that vomiting accompanies hollow viscus distension so that if either the gall bladder or common duct become tensely distended, vomiting may supervene.

Elevations of temperature, pulse, and white blood count are sometimes used as an argument for a bacterial theory of causation. However, the work of Menkin, which is too extensive to be described at this point, clearly shows that a sterile inflammatory reaction causes all of these phenomena, and bacteria are in no way necessary to their development. In short, they are entirely due to products of tissue destruction in the presence of inflammation.

The question now arises as to management of acute cholecystitis. What is the rationale for operating upon such patients? Obviously, the only reason for operation is to prevent

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serious effects following perforation. As has been previously stated, this danger of perforation is more theoretical than real. Cases of perforation have been extremely rare in my experience which has been fairly extensive in this field.

Most patients, then, with acute cholecystitis can, and should be, treated conservatively. However, it is possible with some assurance to tell which patients may go on to perforation and those individuals certainly should be operated upon.

Physical findings of rebound tenderness with such increasing symptoms and signs as in the second case here presented, indicate the necessity for immediate operation. The exact procedure which should be done will depend upon the skill of the operator and also, to some extent, upon the duration of the disease process. If the patient is operated upon within the first twenty-four hours which, however, is unnecessary in the vast majority of cases, cholecystectomy is the procedure of choice. This early operation, however, if the patient has no stones is more radical than necessary. In the absence of stones, acute cholecystitis usually resolves and subsequent x-ray examinations often show a normally functioning gall bladder. If stones are present, cholecystectomy is certainly indicated.

If the skill of the operator does not permit cholecystectomy, or if the patient is operated upon after twenty-four hours, cholecystostomy probably is indicated. This is a poor procedure and is entirely an expedient due to the fact that if stones are present, a subsequent cholecystectomy will be required, and if stones are not present, insertion of the tube rarely permits resumption of normal gall bladder function.

The use of penicillin and sulphadiazine can be dismissed with the statement that neither have any particular value in a non-bacterial disease. Their use is in the nature of a sedative for the surgeon.

It should be mentioned that in cases of acute cholecystitis, amyl nitrate and nitroglycerin usually are without effect. In chronic cholecystitis with stones, they may relieve pain. However, in acute cases, they are valueless because their action depends on muscle relaxation to overcome colicky pain and to allow the gall bladder to empty itself. In acute cholecystitis, even if such relaxation eventuates, the gall bladder cannot empty itself because edematous or stone obstruction persists and the edematous gall bladder wall cannot effectively contract.

The conservative management of acute cholecystitis should include abdominal hot packs and frequent observation.

A cholecystogram during the acute stage is not justified because the dye usually cannot enter the gall bladder because of obstruction and the gall bladder cannot concentrate the dye because of edema. In the cases here presented, the taking of a cholecystogram subsequently as mentioned, is not necessary because the presence of stones already has been verified. Consequently, the usual routine of waiting until the patient's acute inflammatory reaction has completely subsided, followed by cholecystectomy is indicated.

The mechanism by which stones are formed and chronic cholecystitis develops is rightly the subject of a separate discussion.

XV. Chronic Alcoholism and the Conditioned Reflex Treatment by Captain Edward J. Hornick, Chief of Medical Service, 37th Station Hospital (PS), Okinawa.

The following paper was presented by Captain Hornick at the January meeting of the Okinawan Medical Society at the 37th Station Hospital.

It has been said that the most profitable psychological moment in the treatment of alcoholism lies in the remorse-packed period following overindulgence, so it occurred to me that this, our first meeting after the holiday celebrations, would be an appropriate one for the discussion of chronic alcoholism which has been called "the most important unsolved public health

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problem in America." Before launching into my main text of what chronic alcoholism is and how we manage it, I would like to discuss some of the social costs of alcoholism and some of its medico-psychiatric manifestations.

Of 140 millions of persons in the United States, about 50 millions use alcohol, 3 millions use it to excess, and 750,000 are addicts. This 50,000,000 represent quite a bloc of adult voting population; they're the persons who sent prohibition spinning in 1932 and have looked askance at most dry propaganda since. There are 13,000 persons admitted to state hospitals for alcoholic psychoses annually; these represent 6 - 7 percent of the total admissions, or about the same percentage as those admitted for general paresis. Alcoholism shows widespread effects on industrial output, industrial accidents and auto accidents. When we consider together the reported incidence of drinking by drivers and pedestrians, the statistics show that a driver or a pedestrian who had been drinking was reported involved in one out of five total accidents in 1943. Alcoholism costs 13 millions per year in hospitals, and 25 millions per year in jails. The American Hospital Ass'n. went on record in 1945 advocating that 3% of general hospital beds should be put aside for the care of alcoholism. Crimes from alcoholism cost 175 millions per year and a study done on felons at Sing Sing indicated that about 25% of the prisoners were chronic inebriates. The liquor bill for the United States alone was 7.8 billions of dollars last year, of which the liquor industry, or rather you and I, paid almost three billions in taxes. Less easy to estimate is the family and community morbidity, the incalculable loss in creative achievements.

I think I should temper this grim picture by reminding you that for 46 millions of users of alcohol, the drug serves in some measure to reduce tension, guilt, anxiety and frustration. Like William Saroyan's provocative title -- "Aspirin is a Member of the NRA" -- alcohol serves to mend rents in the social fabric, to bridge personal feelings of inadequacy and inferiority, to wet down panics whether they be financial or homosexual. We may liken alcohol to other discoveries of dynamic character, such as the wheel, electricity and atomic energy; it is a human artifact of great power; how it is used or misused is pertinent.

Dr. Fleming of Harvard often demonstrates an instructive chart showing how alcoholism is the symptomatic result of physical, psychological and social pathology, and how in its turn alcoholism produces new physical psychological and social pathology. Let us look for a moment at some of the medical and psychiatric entities associated with alcohol.

Delirium tremens is caused by chronic alcoholism plus a precipitating factor such as fracture, pneumonia or an operative procedure. It may occur weeks after any alcoholic intake. One of my most vivid reminiscences in this corner is an alcoholic of 50 who hadn't had a drop in a fortnight when he was operated for hemorrhoids. At ten that night he told me that he was on Waikiki beach as the Japanese were invading and butchering all in sight. Treatment for jim-jams, the shakes or the rams should be dictated by a maximum of reassurance, a minimum of restraint, paraldehyde for sleep, salt and fluid. There should be no so-called "withdrawal alcohol" and spinal taps are relatively ineffective.

Alcoholic polyneuritis is really a vitamin B1 deficiency, as experiments at Bellevue letting patients continue on a pint of whiskey a day while they had plenty B1 proved. The German Rx of B1 intrathecally has not been validated in this country.

Pathological intoxication is a category dreamed up by defense lawyers whose clients commit mayhem or murder while under the influence of a snort or two of hearty spirits. While there are wide variations in the alcoholic tolerance of persons, most persons who commit acts of violence under such slight stimulus are properly classified as aggressive psychopathic personalities.

The old men who drink themselves literally into the gutter and are removed therefrom by the police with sucking reflexes, forced grasping, cogwheel rigidity, and in coma are said to manifest alcoholic encephalopathy. The original mortality of 95% has dropped to 16% since the use of nicotinic acid. It is a moot question whether it is the specific coenzyme effect of the vitamin or its vasodilatory power which works a cure.

And now we arrive at the crucial problem of our discussion, the structure and meaning

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of chronic alcoholism, which afflicts three-quarters of a million people in the US.

Fenichel has pointed out that "the specific elation from alcohol is characterized by the fact that inhibitions and limiting considerations of reality are removed from consciousness before the instinctual impulses are, so that a person who does not dare to perform instinctual acts may gain both satisfaction and relief with the help of alcohol. The superego has been defined as the part of the mind that is soluble in alcohol." Simon Weigle said that "the weakling becomes strong, the doubters positive, the backward cases talented in their own eyes. The ego can be boundlessly magnified, and the swollen ego is intoxicated with its own perfection and self-sufficiency." Correspondingly the reasons for reverting to alcohol are either the existence of external frustrations, that is, states of misery one would like to forget and to replace by pleasurable fantasies, or internal inhibitions, that is, states in which one dare not act against the superego without such artificial help; among these inhibitions, depression is one of the greatest importance.

When the misery is at an end, the drinking may or may not be at an end. Persons in whom it is not are called alcoholics, and are characterized by their oral and narcissistic pre-morbid personalities. Addicts are persons who have disposition to react to the effects of alcohol in such a way that they try to use these effects to satisfy the archaic oral longing which is sexual longing, a need for security and a need for the maintenance of self-esteem simultaneously. Thus the origina and nature of the addiction are not determined by the chemical effect of the drug but by the psychological structure of the patient. For them it means the fulfillment or at least the hope of fulfillment, of a deep and primitive desire, more urgently felt by them than are sexual or other instinctual longings by normal persons. This pleasure or the hope for it makes genital sexuality uninteresting for them. Erogenously, the leading zones are the oral zone and the skin. Self-esteem, even existence, are dependent on getting food and warmth. The effect of the drug rests on the fact that it is felt as this food and warmth. Persons of this kind react to situations that create the need for sedation or stimulation differently from others. They are intolerant of tension. They cannot endure pain, frustration, situations of waiting. They seize any opportunity for escape more rapidly and may experience the effect of the drug as something much more gratifying than the original situation that had been interrupted by the precipitating pain or frustration. After the elation, pain or frustration becomes all the more unbearable, inducing a heightened use of the drug. The tendency toward such a development, rooted in an oral dependence on outer supplies, is the essence of drug addiction, whether the drug be morphine, marijuana or alcohol. The English have a saying that the child who plays by putting his fingers in his mouth will grow up to be an alcoholic. Knight at the Menninger Clinic has shown that in chronic alcoholics difficult family constellations created specific oral frustrations in childhood. In boys the frustrations resulted in a turning away from the frustrating mother to the father, that is, to -- more or less repressed -- homosexual tendencies.

Alcoholism is therefore best conceived as a secondary or symptomatic disorder. The sick alcoholic is often the last person to recognize his affliction and often persistently refuses treatment other than that designed to put him in good physical shape and enable him to sleep at night. He usually can be positively identified by the fact that regardless of intent he is unable to take alcohol in moderation -- a few drinks are always followed by more. The use of alcohol for other than social purposes, solitary drinking and taking a few to "sober up" the morning after are also ominous occurrences. Seliger calls a person an addict or a compulsive drinker when liquor interfered with his personal or business life, when his personality seems altered. However the borderline between social and pathological drinking is defined, all investigators in the field are agreed that once the line has been crossed, it can never be re-crossed. The chronic alcoholic cannot return to temperate or moderate drinking. It is an all or none phenomenon with him. He must avoid the small glass of wine -- the apparently harmless lapse -- with even more determination than the obvious slug of gin. He must never be so foolish as to try to persuade himself that he can drink beer.

Voegtlin and Lemere in 1942 exhaustively reviewed all methods of treatment of alcohol addiction. They found punishment and enforced hospitalization useless. Prohibition reduces the amount of alcohol consumed but does not reduce the incidence of alcoholism. Psychosocial, religious, prolonged institutionalization, out-patient psychotherapy, psychoanalysis, hypnosis, the elevation of blood sugar, spinal drainage, insulin and metrazol and electric shock, benzedrine, vitamins, atropine strychnine, emetine, apomorphine, rossium, sustained narcosis, lubrokol,

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colloidal gold, prefrontal lobotomy, oxygen, IV alcohol, purgatives, sodium rhodanate, thyroid and a number of other reported curative substances and measures were studied. They concluded that most of these therapies were of little or no curative value. In the best of hands most of them yielded about 35% cures. Remember that complete abstinence is the only acceptable therapeutic goal in alcoholic addiction.

One of the most promising approaches to this problem has been that of Alcoholics Anonymous, an organization of a semi-religious character which admits as members only persons who have known the deepest humiliation of alcoholic debauchery, and are sincerely desirous of changing their way of life. It is one alcoholic to another. In small groups under the guidance of a moderator who has been abstinent at least a year they meet once or twice a week to reinforce their several resurrections. Here there is no talking down by pastor, doctor, or social worker. There is the fellowship of men who have had the same experience with alcohol that they have had. This is the best sort of group therapy. In San Francisco they have an office open all night long to send out helpful posesses to anyone who needs them. Alcoholics Anonymous insists on honesty with oneself and others, the kind of giving for which there is no expected return and prayer. Their large open meetings should be a revelation to each of you.

But you came this evening to hear about the conditioned reflex treatment. This depends fundamentally on the creation of an aversion or distaste for alcoholic beverages by virtue of their association during treatment with drugs which make the patient sick. The repeated association of these two stimuli will result finally in the ability of the conditioned stimulus (liquor) to produce the symptom complex formerly brought about by the unconditioned stimulus (drugs). It isn't a new idea. In the 2nd Century a Roman physician used to put live eels in the wine of alcoholics and force them to drink the animal cocktail. Over 1500 patients have received this treatment at the Shadel Sanataria in the northwest with results that are astounding. Their definition of cure is four years' abstinence and 51.5% of 259 patients fulfilled this requisite. Of 644 patients followed two years or less, 74.8% are still abstinent. And they continue to improve these statistics with reinforcement techniques. Better results are to be expected when patients are carefully selected. The financially indigent, the uncooperative, inadequate, psychotic and deteriorated have a poor prognosis as do females, professional men -- especially doctors -- business executives, bankers, musicians and artists. The desire of the patient to get well and his normality when not drinking are prognostically important. Since the treatment is rather strenuous only those in reasonably good physical condition are accepted.

One treatment is given daily for from four to ten days -- some of the later ones can often be on an out-patient basis. The procedure is carried out in a special treatment room from which all stimuli are excluded except the sight and smell of all liquors to which the patient has been or might be exposed. The patient is told that via treatment a condition will result, such that the sight, smell or taste of liquor will make him sick. He is given a glass of salt solution masking one grain of emetine to irritate his gastric mucosa. He is given by hypo about one grain of emetine HCl and four-tenths grain each of ephedrine and pilocarpine. The emetine is given to lower his vomiting threshold by central action; the pilocarpine to produce diaphoresis and the ephedrine for support. Sitting at a table before the bar, the subject for a period of five to ten minutes opens bottles, smells the contents, tastes some and finally at the moment when the therapist is sure a small additional irritant will produce vomiting, the patient drinks his favorites freely. Timing is all important. The patient then becomes quite nauseated and vomits. Alcohol is immediately administered again and again with similar response each time. Psychotherapy is conducted as circumstances indicate and permit, but it doesn't seem important. Complications consisted in my series of several cases of mild emetine poisoning, one irritative cystitis and localized myositis from emetine. In their first 1000 cases Voegtlin and Lemere reported three deaths from Rx, two from coronary thrombosis, one from congestive failure. Two others died from D.T.s, again several weeks after their active ingestion had ceased. Mortality, 0.28%.

Mr. Shadel, the general manager of the Shadel string of sanataria, has introduced some valuable adjuncts to the core of the conditioned reflex treatments. He issues a booklet containing ten admonitions to the chronic alcoholic, such as "never take that first drink," "do not experiment with drinking," "do not look on alcoholism as a personal weakness," "develop new outlets," "be proud of having stopped drinking." It is prefaced by a quote from Ben Johnson saying "Abstinence would be as easy for me as temperance would be difficult." He employs ex-alcoholics in all departments, as therapists, as initial interviewers and follow-uppers in six states.

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Upon graduation the conditioned alcoholic is presented with a thermometer to hang in his bathroom; on it is inscribed this message, "There is just one thing that I can't do."

The results are dramatic and amusing. For months the patient has to cross the street to pass a bar. One patient couldn't sleep with his wife because she usually had a glass of beer at bedtime. Many reported nausea at the sight of liquor ads in magazines, and one reported getting sick in a theatre when someone with a shot on his breath sat down beside him. The reflex is good for about two months or until the patient gets enough liquor to stay down to narcotize the reflex. A reinforcement program at Shadel consists in having the patient return one to two months after the original treatment and thereafter at 90 day intervals for a year. They record 85% abstinence for one year in persons accepting this program.

The conditioned reflex Rx is not a panacea for alcoholism because the vast majority of those afflicted fail to recognize the true nature of their disorder and decline definitive therapy.

In summary we have discussed something of the social and personal costs of chronic alcoholism, taken a Cook's tour of several disease entities related to alcohol, tackled with questionable success the psychopathology of chronic alcoholism, and elaborated two promising therapeutic angles, that of Alcoholics Anonymous and that of the conditioned reflex. The latter seems to act independently of any rectification of faulty psychological structure. In trained hands the results are amazing.

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PART III

STATISTICAL

Evacuation

During the period 27 Dec 47 to 30 Jan 48, the following patients were evacuated from the several major commands:

	<u>AIR</u>	<u>WATER</u>	<u>TOTAL</u>
JAPAN	160*	132*	292*
KOREA	129**	3	132
MARBO	32	0	32
PHILRYCOM	82	1	83

The following are the evacuations per thousand strength for the period 27 December 1947 to 30 January 1948:

JAPAN	3.4*
KOREA	4.0
MARBO	2.2
PHILRYCOM	1.8
THEATER	3.0

As of 30 January 1948, the following number of patients were awaiting evacuation:

JAPAN	80*
KOREA	21
MARBO	17
PHILRYCOM	11

*Includes air evacuees from Korea.

**Patients evacuated to Japan for onward evacuation

During the period 31 Jan to 27 Feb 48, the following patients were evacuated from the several major commands:

<u>AIR</u>	<u>WATER</u>	<u>TOTAL</u>
210*	2*	212*
100**	4	104
27	0	27
34	2	36

The following are the evacuations per thousand strength for the period 31 January to 27 February 1948:

2.7*
3.5
1.5
.77
2.2

As of 27 February 1948, the following number of patients were awaiting evacuation:

137*
19
3
13

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Hospitalization

The Bed Status Report as of 26 December 1947 will be listed under column (a).
The Bed Status Report as of 30 January 1948 will be listed under column (b).
The Bed Status Report as of 27 February 1948 will be listed under column (c).

	Total T/O Beds Authorized			Total T/O Beds Established			Total T/O Beds Occupied		
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)
JAPAN	4,450	4,450	4,450	4,450	4,450	4,450	1,750	2,027	1,985
KOREA	2,050	2,050	2,050	1,507	1,468	1,286	629	733	661
MARBO	575	575	825	575	575	825	219	253	223
PHILRYCOM	2,350	2,350	2,350	1,984	1,944	1,964	1,188	1,249	1,233
THEATER	9,425	9,425	9,675	8,496	8,437	8,525	3,786	4,262	4,102

The percent of T/O beds and operating beds occupied for the period ending 26 December 1947 will be listed under column (a).
The percent of T/O beds and operating beds occupied for the period ending 30 January 1948 will be listed under column (b).
The percent of T/O beds and operating beds occupied for the period ending 27 February 1948 will be listed under column (c).

	Percent Authorized T/O Beds Occupied			Percent of Established Beds Occupied		
	(a)	(b)	(c)	(a)	(b)	(c)
JAPAN	39	46	45	39	46	45
KOREA	31	36	32	42	50	51
MARBO	38	44	27	38	44	27
PHILRYCOM	51	53	52	60	64	63
THEATER	40	45	42	45	51	48

ADMISSION RATES PER 1,000 PER ANNUM

All Causes						Disease					
WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM	WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	609	693	710	362	455	5 Dec 47	552	640	645	311	395
12 Dec 47	622	673	756	481	468	12 Dec 47	568	627	683	411	422
19 Dec 47	661	749	778	436	496	19 Dec 47	606	704	698	367	443
26 Dec 47	507	569	689	344	315	26 Dec 47	447	515	623	231	271
MO ENDING						MO ENDING					
30 Jan 48	651	770	812	379	424	30 Jan 48	595	714	740	318	383
27 Feb 48	630	791	769	305	397	27 Feb 48	577	729	710	251	359
Injury						Psychiatric					
WK ENDING						WK ENDING					
5 Dec 47	56	52	66	51	60	5 Dec 47	15	16	20	19	7.6
12 Dec 47	53	46	73	71	46	12 Dec 47	14	18	13	20	4.4
19 Dec 47	56	45	79	69	54	19 Dec 47	13	12	18	16	12
26 Dec 47	60	54	66	113	44	26 Dec 47	11	10	17	14	6.7
MO ENDING						MO ENDING					
30 Jan 48	55	56	71	62	41	30 Jan 48	15	14	23	20	9.3
27 Feb 48	54	61	59	53	38	27 Feb 48	15	15	25	15	9.7

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Rheumatic Fever

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	.8	1	0	0	1
12 Dec 47	.5	1	0	0	0
19 Dec 47	2.	4	1	0	0
26 Dec 47	.5	1	0	0	0
MO ENDING					
30 Jan 48	1.1	1.1	1.6	0	1.3
27 Feb 48	1.1	1.8	.4	0	.8

Common Respiratory Disease

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	95	115	133	16	56
12 Dec 47	114	140	152	17	68
19 Dec 47	110	123	196	5	64
26 Dec 47	85	102	133	8	45
MO ENDING					
30 Jan 48	115	140	188	35	49
27 Feb 48	110	130	219	7.8	47

Influenza

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	3.1	6.3	0	0	0
12 Dec 47	3.9	6.9	3	0	0
19 Dec 47	3.8	6.2	3	3	0
26 Dec 47	1.9	3.3	2	0	0
MO ENDING					
30 Jan 48	2.4	4.0	1.9	0	.67
27 Feb 48	2.7	4.7	1.7	1.4	.55

Primary Atypical Pneumonia

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	6.4	6	14	0	4
12 Dec 47	3.7	3	7	0	3
19 Dec 47	8.9	4	12	0	4
26 Dec 47	4.1	3	12	3	1
MO ENDING					
30 Jan 48	7.7	5.8	21	1.7	4.0
27 Feb 48	5.6	5.1	15	.71	2.5

Common Diarrhea

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	6.7	1	26	0	7
12 Dec 47	7.0	4	20	0	7
19 Dec 47	7.8	3	15	8	11
26 Dec 47	7.9	4	23	0	8
MO ENDING					
30 Jan 48	7.7	2.8	29	0	4.9
27 Feb 48	6.8	3.1	18	0	8.6

Bacillary Dysentery

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	.8	0	0	0	3
12 Dec 47	1.	.5	0	0	3
19 Dec 47	.3	0	0	3	0
26 Dec 47	.5	0	0	0	2
MO ENDING					
30 Jan 48	.56	0	.63	0	1.8
27 Feb 48	.89	.16	.9	0	2.5

Amebic Dysentery

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	.8	0	0	0	3
12 Dec 47	1.6	0	0	0	7
19 Dec 47	1.3	1	0	0	3
26 Dec 47	.5	0	0	0	2
MO ENDING					
30 Jan 48	1.6	.60	1.3	0	4.5
27 Feb 48	1.8	.49	2.6	.71	3.9

Malaria

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	5.9	0	0	3	24
12 Dec 47	7.6	1	0	0	23
19 Dec 47	7.3	.6	0	0	23
26 Dec 47	2.9	.6	2	0	10
MO ENDING					
30 Jan 48	3.9	.72	.63	8.9	10
27 Feb 48	4.6	1.1	1.7	.71	14

Infectious Hepatitis

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	3.1	0	7	11	3
12 Dec 47	3.7	0	10	3	7
19 Dec 47	3.8	4.5	6	0	2
26 Dec 47	1.4	1.6	0	0	2
MO ENDING					
30 Jan 48	2.9	2.6	6.3	.55	1.8
27 Feb 48	4.4	4.4	6	5.7	2.8

Mycotic Dermatoses

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	2.8	3	6	0	1
12 Dec 47	6.6	7	10	0	6
19 Dec 47	3.2	6	1	0	0
26 Dec 47	3.2	2	6	0	4
MO ENDING					
30 Jan 48	4.7	6.3	5.9	0	2.7
27 Feb 48	6.4	7.5	9.9	0	4.7

Venereal Disease

WK ENDING	THEATER	JAPAN	KOREA	MARBO	PHILRYCOM
5 Dec 47	93	125	74	22	71
12 Dec 47	92	108	91	34	84
19 Dec 47	108	148	102	27	66
26 Dec 47	81	114	74	30	42
MO ENDING					
30 Jan 48	104	153	87	21	58
27 Feb 48	95	140	87	25	52

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